❑ Initiate Waiver services
❑ Service Modification
  □ Add a service
  □ Increasing hours of service
  □ Decreasing hours of service
❑ Change in SF (requires 2 ISARs)
❑ End CD service

MR Waiver
Consumer-Directed Respite
Individual Service Authorization Request

CSB _____

CSB provider #

_____

Name: _____ Medicaid No. _____
Last, First MI

Address:_____
_
Street/Apt City, State Zip Code

Phone No._____ Social Security No._____

Patient Pay Amount $_____ Is this service designated to collect patient pay? ☐Yes ☐No ☐N/A

Services Facilitator (SF)_____ _____ Provider No. Reassessment? Yes____ No____
SF agency, if applicable_____

Will the individual be directing his or her own services? ☐ Yes ☐ No	If NO, name and relationship of responsible family member/caregiver:

SERVICE TO BE PROVIDED	YEARLY HOURS NEEDED	OMR USE ONLY
Fill in applicable dates: **CD Respite** services start date may not precede: SF Start Date:_____ SF End Date: _____ S5150--CD Respite Start Date: _____ S5150--CD Respite End Date: _____		

Reason for this request: _____

Not available to individuals living with paid caregivers. Maximum is 720 hours per calendar year (including agency-directed).
Check the allowable activities included in the individual's ISP.

Assistance with
☐ activities of daily living
☐ monitoring health status & physical condition
☐ self-medication and/or other medical needs
☐ meal preparation and eating
☐ housekeeping activities
☐ participating in recreational activities
☐ appointments or meetings
☐ bowel/bladder programs, range of motion exercises, routine wound care (per MD's orders and RN oversight)
☐ general support to assure safety

Training for assistant
☐ as requested by the individual or caregiver that relates to services described in the ISP

Comments:

If applicable, list any current or previously authorized Respite providers and total number of hours used since January of this year:_____ (Hrs. used)

_____ _____
Signature of Facilitator Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

_____ _____ _____
CSB Rep/ Case Manager (print) Phone No. Fax No.

_____ _____
Signature Date

DMAS-419 Rev. 08/04